2002 Dental Report

MANAGED RISK MEDICAL INSURANCE BOARD

Correction

On page 26, this report indicates that the California Children's Services Program (CCS) would be implementing changes to the orthodontic program in the fall of 2003. The Managed Risk Medical Insurance Board has been advised that implementation will actually begin in the fall of 2002. Page 26 of this report has been revised to reflect the correct date.

We apologize for any inconvenience this may have caused.

2002 Dental Report

MANAGED RISK MEDICAL INSURANCE BOARD

Healthy Families Program Dental Services Report 2002

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Highlights

This report provides an update on the HFP dental program. Access to dental care is of growing interest to policy makers. This report is intended to serve as a basis for discussion on ways to improve the HFP dental program.

This report provides a variety of information on program performance. Highlights include:

- The majority of HFP children (64%) are enrolled in "open network model" dental plans.

- The statewide dentist to subscriber ratio in the HFP is 1 dentist for every 54 subscribers. This ratio compares favorably to dentist to subscriber ratios in the Medi-Cal and commercial markets.

- Fifty-six percent of children ages 4-19 who were enrolled in the HFP for at least one year received a dental visit during calendar year 2000. This compares favorably with national Medicaid data that indicates 36% of children received a dental visit. Commercial comparison data was not available.

- During the 2001 open enrollment, four percent of families chose to transfer their children between dental plans. Nine percent of families with children enrolled in "primary care model" dental plans chose to move their child to a new dental plan; three percent of families with children enrolled in "open network model" dental plan chose to transfer plans. Of those families who chose to transfer dental plans, the majority transferred to an open model plan.

- In the first ever survey of dental plan satisfaction, the majority of HFP subscriber families gave the highest ranking to their child's

    - HFP dentist,
    - HFP dental plan,
    - HFP dental care,
    - ability to get needed dental care,
    - ability to get care quickly,
    - how well the dentist communicates, and
    - how well they and their child were treated.

    While overall HFP satisfaction ratings were high; significant variations exist between the "open network model" and "primary care model" dental plans. The open network model consistently scored above the program average. Because this is the first time this survey has been conducted comparative data is not available.

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Healthy Families Program Dental Services Report 2002

Over 730,000 previously uninsured children have gained access to dental coverage through the Healthy Families Program (HFP). Dental services provided by the HFP are based on the State employee dental benefits plan, which is administered by the Department of Personnel Administration. Children receive comprehensive preventive, restorative and other major services with limited ($5 for some services) or no copayment (for preventive and restorative services).

MRMIB members and other stakeholders have expressed an increasing interest in the access and quality of dental services received through the HFP. In 2000 and 2001, the HFP Advisory Panel held a series of discussions regarding the adequacy of access to dental providers and dental services. During this same time period, the Legislature held two hearings regarding dental services provided to children in Medi-Cal and the HFP.

To facilitate discussions about dental services provided through the HFP, a status report was prepared in 2001 that summarized the dental plan network, utilization rates, and quality of services. Data presented in the 2001 report was based on the early experience of the program. Also at that time, information about dental services from the subscriber's perspective was not available.

This report seeks to update the first report on HFP dental services. New information on the utilization of services and the level of access to services is presented. In addition, results from the first dental consumer survey are included.

Background

Insurance Code Section 12693.39(a) instructs the Managed Risk Medical Insurance Board to contract with a sufficient number of plans to allow adequate access for subscribers. From the inception of the program, a minimum of four dental plans have participated in the program. A fifth dental plan, Universal Care Dental, was added to the program in 2000. The dental plans that participate in the program can be grouped into two models: the Primary Care model and the Open Network model.

- Primary Care Model

  Three of the five dental plans participating in the HFP are Primary Care model plans: Access Dental, Denticare and Universal Care Dental. **Thirty-five percent of HFP subscribers are enrolled in these plans**. This model requires subscribers to select a primary care dentist (PCD) who is responsible for coordinating the subscriber's dental care. Subscribers can select a pediatric dentist as their primary care dentist. Non-emergency referrals to specialists in the primary care model require prior-authorization from the primary care dentist. Primary care dentists accept a capitation payment from the plan for each assigned member. Access Dental and DentiCare allow subscribers to change PCD once a month. Universal Care Dental requires notification 15 days prior to the requested change.

  Primary Care model plans conduct site reviews of the network providers to inspect numerous areas of the office such as parking/handicap access, cleanliness of the office, sterilization of instruments and operatories, access to care and emergency protocols relating to the patient. Primary care model dental plans credential their network providers. This involves verifying the status of the

dentist's licenses and school of graduation and post graduate training. Dental Consultants visit offices to check patient charts to see that appropriate dental treatment is being planned and completed. Billing practices are also checked to see if providers are charging the members correctly. Provider credentialing is repeated every two years.

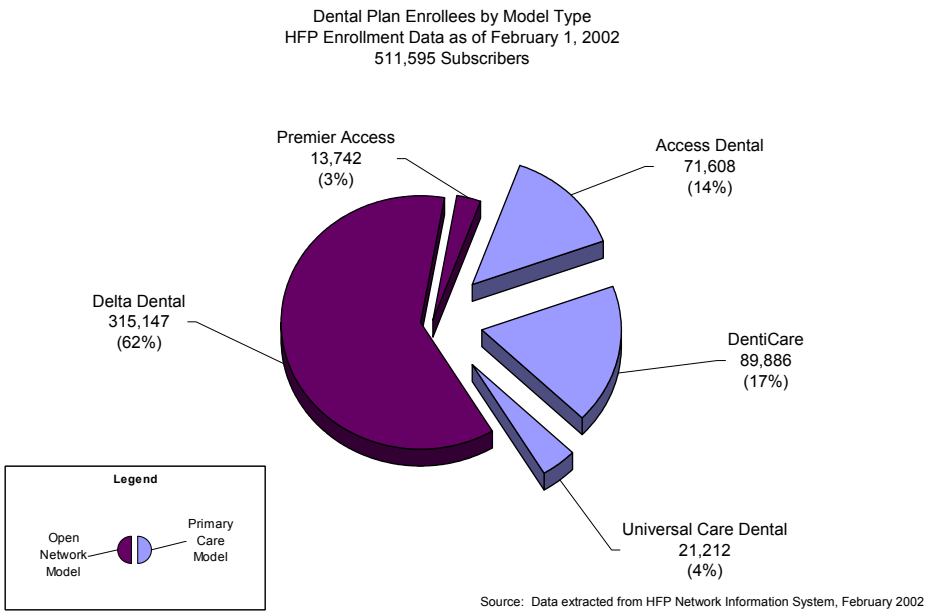
- Open Network Model

  Two of the five dental plans participating in the HFP are Open Network models: Delta Dental and Premier Access. **These plans serve sixty-five percent of all HFP members**. In this model, subscribers select any dentist (including a pediatric dentist) from the dental plan's network. This selection is made each time services are accessed. Referrals to specialists do not require prior-authorization. Dental providers are paid on a fee-for-service basis for services rendered to the subscriber. Subscribers can change dentists an unlimited number of times without prior authorization.

  Open Network Models may conduct site reviews of network providers on a random basis and on a targeted basis (utilization and/or grievances). Providers are credentialed with recredentialing repeated at least every two years.

Chart 1 illustrates the distribution of HFP subscribers among the two network models and among the five dental plans participating in the program.

Chart 1



Dental Plan Participation in HFP

Participation of dental plans in the HFP is determined through the competitive contract negotiation process used by MRMIB. Dental plans interested in participating in the program must: 1) have a license to provide dental services in California, 2) agree to provide benefits consistent with program regulations, and 3) agree to follow all program rules. In addition, plans are evaluated on several criteria. Key among these are price and access.

With respect to price, dental plans are evaluated on the cost-effectiveness of their rate proposals. The cost-effectiveness is based on 1) whether the proposed rates are "actuarially" reasonable given the benefits that must be provided and 2) whether the proposed rates place the plan within a county's family value package (FVP). Once the initial price proposals are accepted, the rates are then reviewed in the context of the FVP. The FVP is the average price of the two lowest price proposals for health, dental and vision in each county, plus 7.5 percent. Once the FVP is established, any dental plan with a price proposal that falls within the package (when combined with the lowest priced health and vision plans) is considered for participation in the HFP in that county. (The FVP is described in the HFP statute and regulation. Any change to the FVP calculation method requires a change in law or regulation.)

The accessibility of the dental plans' networks is evaluated by using several approaches. During the initial implementation of the HFP, all participating dental plans were reviewed by the Department of Corporations to ensure that their existing dental provider networks were adequate to serve the HFP. Each dental plan is required annually to provide information on the number of dental providers available by county, the number of dental providers accepting new patients by county, and the estimated capacity or number of additional subscribers that the dental providers can enroll in a county. MRMIB also reviews the number of access-related complaints received from the plans' subscribers. If it is determined that a plan's provider network is not adequate in a particular service area, MRMIB has the option of removing that plan as a participating plan in that service area.

The competitive negotiation process occurs annually and has resulted in changes to the program since the beginning of the program. The first changes occurred for the 2000/2001 benefit year.

In the 2000/2001 benefit year, Delta Dental did not submit a rate within the FVP in Los Angeles, Ventura and Orange counties and was closed to new enrollment in these three counties on July 1, 2001. To prevent a disruption in patient-provider relationships, MRMIB amended the FVP regulations allowing existing subscribers and their siblings to remain enrolled in Delta Dental in these counties. Also during this benefit year, Universal Care Dental was added to the program.

In the following benefit year (2001/2002), Delta Dental submitted a price that was within the FVP and reopened to new subscriber enrollment on a statewide basis. However, new subscriber enrollments in Delta Dental during 2001/2002 were limited to 28,000 children in Los Angeles County, 7,000 in Orange County, and 7,000 in Riverside County.

Access Dental replaced its Primary Care Model with its Open Network Model, Premier Access, in seven counties (Butte, Madera, Shasta, Sutter, Tulare, Yolo, and Yuba) affecting 1,700 subscribers. These subscribers were allowed to select a new dental plan in their area, which included the option of selecting Premier Access, during open enrollment.

The most recent negotiation process has resulted in yet another set of changes. In the 2002/2003 benefit year, Universal Care Dental will cover all of Los Angeles County except Catalina Island. Denticare will move from full coverage to partial coverage in Santa Clara County. Delta Dental will again restrict enrollment to current enrollees and their family members (including parents) in three counties: Los Angeles County, San Bernardino County, and Riverside County. New subscribers in these three urban counties can select Access Dental, DentiCare or Universal Care Dental as their dental plan.

Access to Dental Providers

The dental plans participating in the HFP provide services to subscribers through 9,450 dental providers[1]. This report evaluates HFP subscriber's ability to access dental services in the following ways: 1) network capacity in terms of dentist to patient ratios, and (2) the percentage of providers open to new enrollees.

Network capacity in terms of Dentist to Patient ratio

The Department of Managed Health Care (DMHC) regulates and licenses managed care dental plans in the State. Dental plans are classified as "Specialized Health Care Plan Contracts" and are subject to the same licensing requirements as Full Service Health Plan Contracts. Section 1300.67.2(d) of Title 28, California Code of Regulations requires health plans to maintain a ratio of one full-time equivalent provider to each 1,200 enrollees (1:1,200) and one primary care provider for each 2,000 enrollees (1:2,000) to ensure the adequacy of the plan's provider networks. These ratios also ensure that all services offered are accessible to enrollees without delay. Although the DMHC does not mandate specific dentist-to-patient ratios, the DMHC generally applies the ratio of one primary care dentist per 2,000 patients in assessing dental provider capacity. This ratio is used as a guideline to evaluate dental provider access in the HFP.

[1] This is based on an unduplicated count of dentists listed on the HFP Network Information Service as of January 2002.

As of January 1, 2002, the HFP had 506,635 subscribers and a total of 9,450 dentists participating in HFP dental plan's provider networks to serve them. On a statewide average, there was one provider for every 54 HFP subscribers in 2001. This ratio remained stable in 2002. While the ratio does not consider the number of patients who are not HFP subscribers in the provider's network, it remains well within the DMHC enrollee to staff ratio requirements.

Subscribers in HFP's dental program have relatively low provider to member ratios in comparison to similar programs. A recent study commissioned by the Medi-Cal Policy Institute evaluated access to dental care in the California Department of Health Services' Geographic Managed Care (GMC) dental program[2]. The GMC was established in 1994 as an alternative managed care option to Denti-Cal. Medi-Cal beneficiaries can choose to participate in either GMC or Denti-Cal[3].

A provider to member ratio comparison was made between GMC (a primary care model plan) and Denti-Cal (an open network plan) to determine if beneficiaries had access to a sufficient number of providers. The report indicated that provider to member ratios were high in both programs. Denti-Cal had 1 provider for every 577 beneficiaries, while GMC had 1 provider for every 564 beneficiaries. Commercial plans, according to this report, had ratios ranging from 1:360 to 1:400. The report acknowledged that an unqualified comparison to commercial plans may not be appropriate due to the higher than average dental treatment needs of low-income populations, the reluctance of some providers to participate in Denti-Cal and GMC programs, and the variances in the productivity of dental practice.

With a stable statewide average ratio of 1 provider for every 54 subscribers (1:54), HFP appears to provide its subscribers with superior access to services when compared to other public health insurance plans and commercial plans with similar plan model types.

Staff notes that these HFP ratios are calculated based on information from the dental plans. There is some concern regarding the accuracy of the plan's data on their provider networks. For example, if a dental plan has a contract with provider X, the provider will be counted as part of the network. If provider X then decides to discontinue participation in HFP, the dental plans may or may not know of this decision. MRMIB is working with dental plans to increase the accuracy of the provider network listings.

Table 1 provides county level dentist to subscriber ratios for the HFP. Regional variations in the ratio reflect the uneven distribution of dental providers in California.

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[2] William M. Mercer, Inc, (2001). *Geographic Managed Care Dental Program Evaluation*. Oakland, CA; Medi-Cal Policy Institute, pp 5-6.

[3] Based on information from "Medi-Cal and Dental Health Services", (1999, January). *Medi-Cal Policy Institute,* Number 6.

Table 1 **Geographic Distribution of Dental Providers in HFP Network Information System**

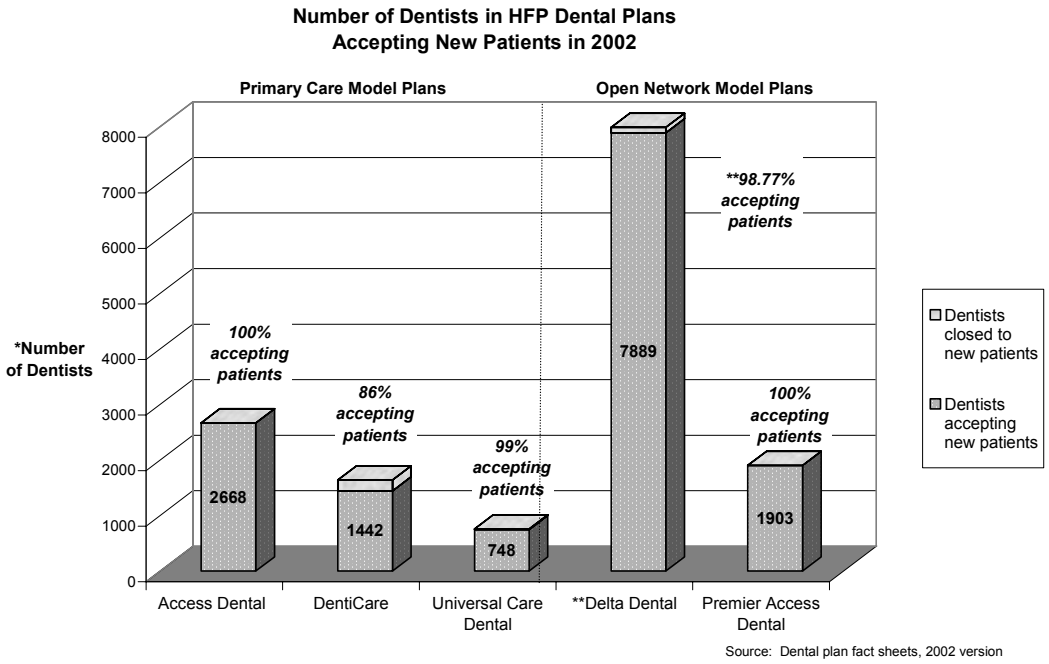
2001				2002			
County Designations	# of HFP Subscribers as of **01/01/2001**	**Dentist to Subscriber ratio**	Total # of HFP Dentists	County Designations	# of HFP Subscribers as of **01/01/2002**	**Dentist to Subscriber Ratio**	Total # all HFP Dentists
Alameda	7,519	**1:46**	164	Alameda	10,495	**1:48**	217
Alpine	15	**--**	0	Alpine	8	**--**	0
Amador	259	**1:43**	6	Amador	333	**1:48**	7
Butte	2,163	**1:75**	29	Butte	2,674	**1:41**	65
Calaveras	308	**1:308**	1	Calaveras	431	**1:144**	3
Colusa	901	**1:901**	1	Colusa	1,064	**1:39**	27
Contra Costa	3,980	**1:71**	56	Contra Costa	5,636	**1:66**	86
Del Norte	228	**1:57**	4	Del Norte	324	**1:46**	7
El Dorado	1,231	**1:82**	15	El Dorado	1,662	**1:52**	32
Fresno	10,624	**1:77**	135	Fresno	14,648	**1:49**	296
Glenn	744	**1:186**	4	Glenn	894	**1:50**	18
Humboldt	1,105	**1:69**	16	Humboldt	1,405	**1:56**	25
Imperial	2,410	**1:172**	14	Imperial	2,945	**1:109**	27
Inyo	132	**1:44**	3	Inyo	165	**1:24**	7
Kern	8,854	**1:74**	119	Kern	12,591	**1:65**	194
Kings	1,634	**1:109**	15	Kings	2,214	**1:96**	23
Lake	883	**1:126**	7	Lake	1,151	**1:89**	13
Lassen	180	**1:60**	3	Lassen	283	**1:71**	4
Los Angeles	114,636	**1:40**	2,873	Los Angeles	154,359	**1:39**	3,946
Madera	1,881	**1:470**	4	Madera	2,536	**1:149**	17
Marin	1,254	**1:78**	16	Marin	1,545	**1:70**	22
Mariposa	231	**1:116**	2	Mariposa	252	**1:84**	3
Mendocino	1,302	**1:69**	19	Mendocino	1,655	**1:57**	29
Merced	3,758	**1:111**	34	Merced	4,909	**1:100**	49
Modoc	76	**1:25**	3	Modoc	113	**1:28**	4
Mono	207	**1:52**	4	Mono	297	**1:33**	9
Monterey	6,548	**1:149**	44	Monterey	9,430	**1:94**	100
Napa	1,084	**1:136**	8	Napa	1,223	**1:111**	11
Nevada	987	**1:58**	17	Nevada	1,474	**1:87**	17
Orange	35,717	**1:48**	748	Orange	48,568	**1:49**	987
Placer	1,403	**1:23**	62	Placer	1,881	**1:21**	91
Plumas	160	**1:27**	6	Plumas	226	**1:23**	10
Riverside	20,877	**1:67**	310	Riverside	32,022	**1:81**	396
Sacramento	7,621	**1:48**	159	Sacramento	10,969	**1:44**	249
San Benito	770	**1:77**	10	San Benito	1,059	**1:81**	13
San Bernardino	22,366	**1:53**	420	San Bernardino	34,000	**1:69**	492
San Diego	28,924	**1:66**	440	San Diego	42,493	**1:74**	576
San Francisco	8,338	**1:55**	151	San Francisco	9,438	**1:54**	174
San Joaquin	8,460	**1:119**	71	San Joaquin	11,422	**1:89**	129
San Luis Obispo	2,521	**1:115**	22	San Luis Obispo	3,145	**1:131**	24
San Mateo	3,057	**1:40**	76	San Mateo	4,225	**1:58**	73
Santa Barbara	4,150	**1:92**	45	Santa Barbara	5,725	**1:89**	64
Santa Clara	9,703	**1:43**	228	Santa Clara	14,121	**1:45**	314
Santa Cruz	2,517	**1:101**	25	Santa Cruz	3,237	**1:98**	33
Shasta	2,898	**1:116**	25	Shasta	3,403	**1:76**	45
Sierra	15	**1:15**	1	Sierra	21	**1:11**	2
Siskiyou	473	**1:95**	5	Siskiyou	551	**1:79**	7
Solano	2,349	**1:50**	49	Solano	2,931	**1:51**	58
Sonoma	4,539	**1:108**	42	Sonoma	5,727	**1:133**	43
Stanislaus	4,843	**1:93**	52	Stanislaus	6,744	**1:90**	75
Sutter	1,660	**1:104**	16	Sutter	1,908	**1:87**	22
Tehama	808	**1:404**	2	Tehama	1,016	**1:203**	5
Trinity	255	**1:64**	4	Trinity	286	**1:57**	5
Tulare	6,812	**1:162**	42	Tulare	8,998	**1:143**	63
Tuolumne	556	**1:70**	8	Tuolumne	693	**1:69**	10
Ventura	8,466	**1:65**	130	Ventura	11,824	**1:89**	133
Yolo	1,423	**1:41**	35	Yolo	2,127	**1:28**	75
Yuba	852	**1:39**	22	Yuba	1,159	**1:48**	24
TOTALS (2001)	**367,667**	**1:54**	**6,822**	**TOTALS (2002)**	**506,635**	**1:54**	**9,450**

*Source: HFP Enrollment Data and HFP Provider Network Data as of January 2001 and 2002 03/2002

Percentages of providers open to new enrollees

Dental plans report 97 percent[4] of the dentists in their HFP networks are accepting new patients as of January 1, 2002. In comparison, approximately 92 percent of dentists participating in Medi-Cal's Geographic Managed Care (GMC) plans are accepting new patients. Dental industry averages for offices closed to new patients in similar managed care programs range from at least 8% to 10%.[5] With only 3 percent of its dentists closed to new patients, HFP's network provides its subscribers with access comparable to industry averages and similar dental delivery systems such as Medi-Cal.

Chart 1



* Number of dentists based on duplicated count due to practice in multiple offices.
** Delta Dental Dentists in Los Angeles, San Bernardino, and Riverside counties will be closed to new patients in the 2002 - 2003 Benefit year.

[4] 97 percent is the average of all participating dental plans' reported percentage of dentists accepting new patients.
[5] William M. Mercer, Inc, (2001). *Geographic Managed Care Dental Program Evaluation*. Oakland, CA; Medi-Cal Policy Institute, pp.61-63

Dental Quality Measures

Regular visits to the dentist ensure the early diagnosis and treatment of dental problems in children (American Dental Association).

The dental plans that participate in HFP are required to submit data on five quality measures. One of these measures, the Annual Dental Visit, comes from the National Committee for Quality Assurances (NCQA) HEDIS 2001. HEDIS® is a nationally recognized tool to evaluate services provided by managed care plans. The remaining four measures were developed by the HFP Quality Improvement Work Group.

The Quality Improvement Work Group worked to increase the number of quality measures that were reported by participating dental plans. Because the number of dental-related quality measures in HEDIS® was limited, the Work Group, through its Dental Quality subcommittee, developed additional quality measures. The measures that were developed were based on preventive services that subscribers are expected to receive and are covered in guidelines for pediatric dental care.

Instructions for reporting these additional measures were based on instructions for the HEDIS® Annual Dental Visit measure. Dental plans used one of two generally accepted data collections methodologies. Dental plans could either search selected administrative data bases (e.g., enrollment, claims, and encounter data systems) for evidence of a service or select a random sample of eligible members and search their administrative databases for information about whether each individual in the sample received a service. If no information is found, the plan is allowed to consult medical records for evidence that the service was provided. Dental plans are required to have their reports independently audited by a certified NCQA HEDIS® auditor.

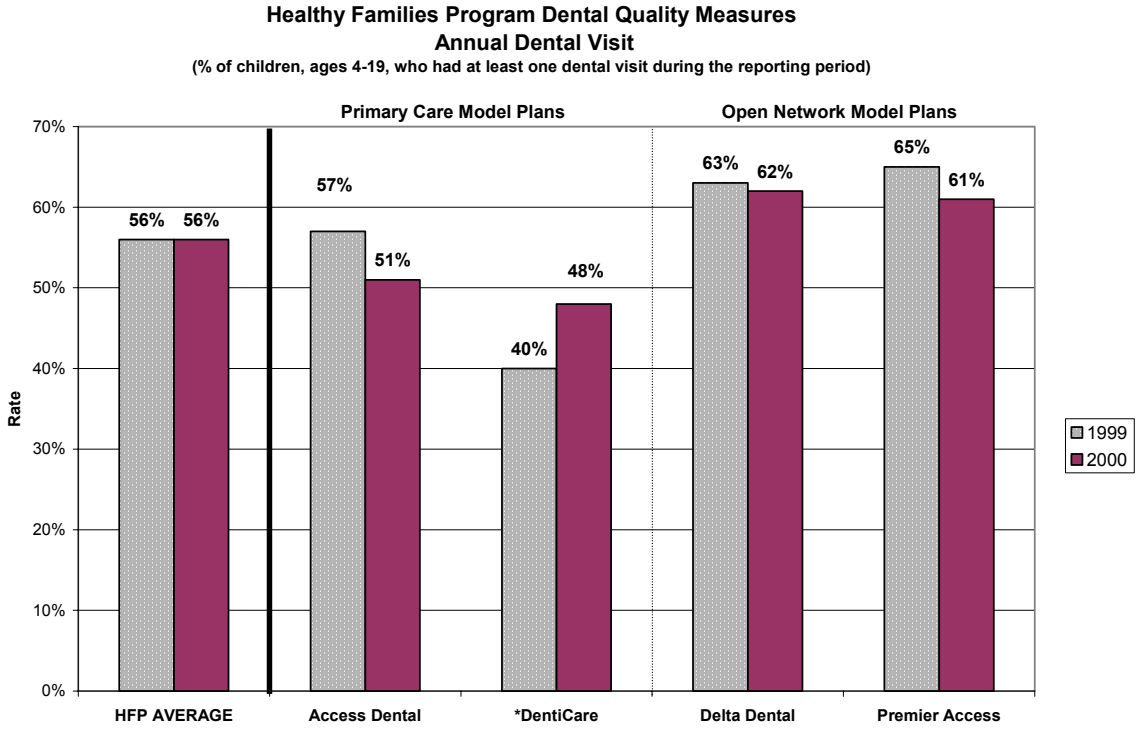
For the 2000 and 2001 calendar years, participating dental plans reported the number of children who received: an annual dental visit, a 120 day dental assessment, periodic dental (recall) examinations and a prophylaxis (dental cleaning) service. These dental quality measures represent the percentage of children receiving a particular service who were continuously enrolled in the HFP during the reporting period, (January 1, 2000 to December 31, 2000), with only one gap in enrollment for a period of no more than 30 days. Charts 2 through 5 shows the percentage of eligible children enrolled in the dental plans in 1999 and 2000 who received services by dental plan and plan model type.

In comparing the HFP dental quality averages from 1999 to 2000, there was no change in the percentage of subscribers who received at least one dental visit during the year. **Fifty-six percent of HFP subscribers received an annual dental visit in both years.** There was a 2 percentage point reduction (from 47% to 45%) in the number of subscribers who had a dental cleaning in 2000. There was a 9 percentage point improvement (from 9% to 18%) in the number of subscribers who had a periodic (recall) dental examination.

Annual Dental Visit

This measure is the percentage of enrolled members, ages 4 through 19, who were continuously enrolled during the measurement year (1/1/00 to 12/31/00) who had at least one dental visit during the measurement year. In both 1999 and 2000, 56% of children meeting the measurement criteria received an annual dental visit.

Chart 2



Standard deviation is (+/-11%) for 1999 and (+/- 7%) for 2000 . Source: 2000 and 2001 audited Annual Dental Quality reports from plans.

*DentiCare was 1 standard deviation below the HFP average in 1999.

Universal Care Dental had an insufficient number of eligible members to participate in measures.

Research shows that approximately 60% of commercially insured persons, ages 18 or younger, will use their dental benefits in a 12-month period of continuous coverage. For Medicaid beneficiaries, ages 18 or younger, it is expected that approximately 35% will use their dental benefits in a 12-month period of continuous coverage.[6]

Studies show a clear drop off in screenings from the first to subsequent years of coverage, so that children in their first year of coverage may have as much as a 1.5 times greater likelihood of having a service compared to children who have had dental coverage for more than a year. When services are received at all, nearly all children receive preventive services, and generally about 1/3 of those children receive restorative treatment[7].

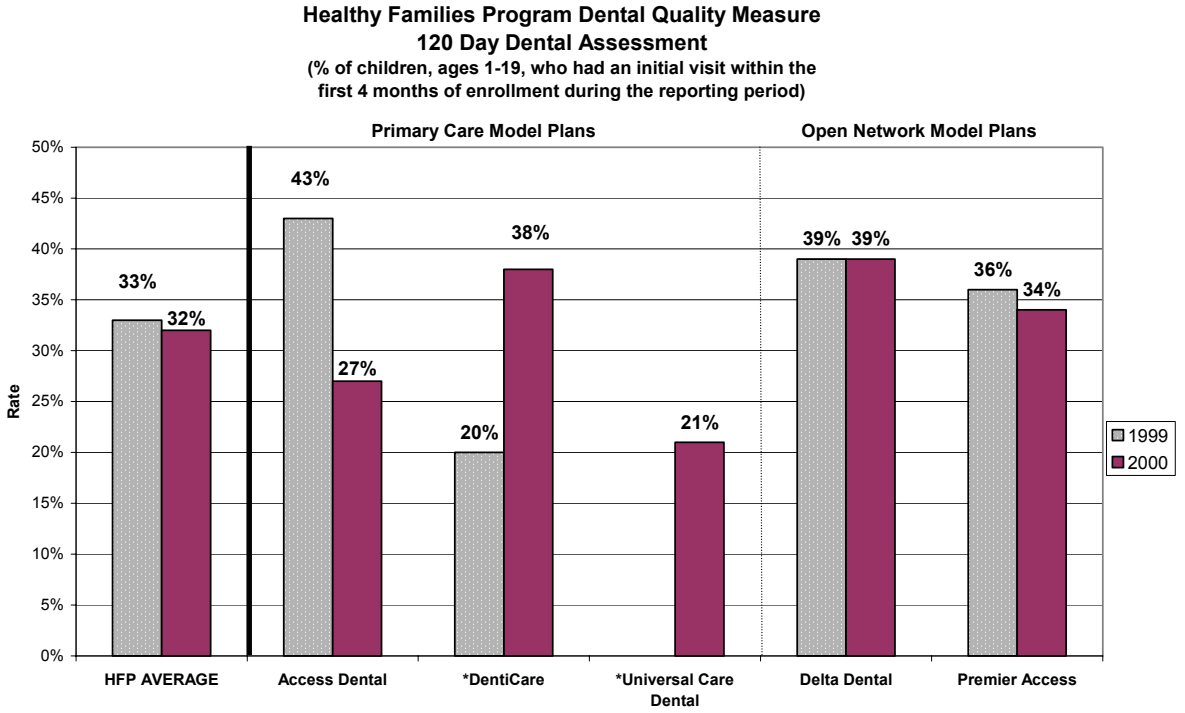
[6] Information provided to MRMIB by Milliman USA, Consultants and Actuaries, April 22, 2002.
[7] Information provided by MRMIB's actuary, Price Waterhouse (PWC), April 2002.

120 Day Dental Assessment

This measure is the percentage of all children between the ages of one year and 19 years of age who were continuously enrolled during the reporting period (1/1/00 to 12/31/00) for a period of at least four months who had an initial visit within the first four months of enrollment. Thirty-two percent (32%) of subscribers eligible for the measure received a 120 day dental assessment in 2000.

In comparison, about 30% of new members in the Geographic Managed Care (GMC) program, (a primary care model plan administered by the Department of Health Services for Medi-Cal recipients in Sacramento) received initial dental assessments within the 90-120 day window[8].

Chart 3



Standard deviation is (+/- 10%) for 1999 and (+/- 8%) for 2000.

DentiCare was 1 standard deviation below the HFP average in 1999.

Source: 2000 and 2001 audited Annual Quality reports from plan

Universal Care Dental was 1 standard deviation below the HFP average in 2000.

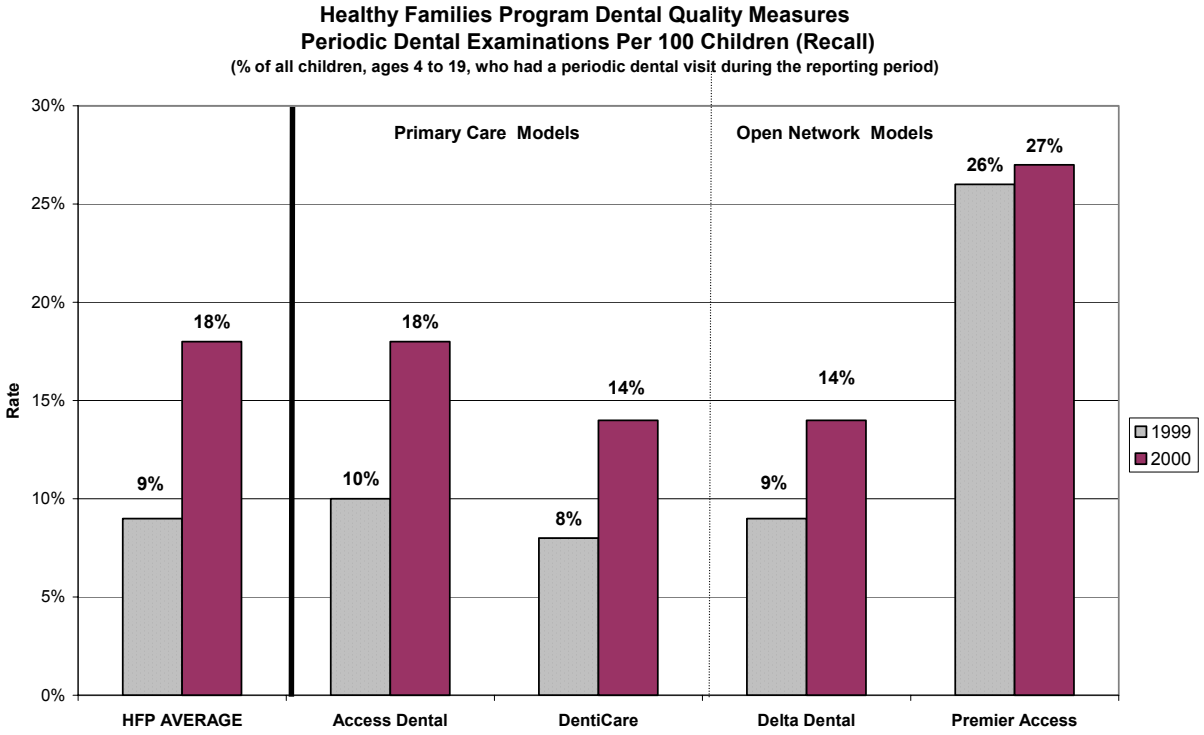
*Universal Care Dental had an insufficient number of eligible members to participate in measures in 1999.

[8] William M. Mercer, Inc, (2001). *Geographic Managed Care Dental Program Evaluation*, full report, Oakland, CA; Medi-Cal Policy Institute, p. 77.

Periodic Dental Examinations per 100 children

This measure is the percentage of all children between the ages of 4 and 19 years of age, who were continuously enrolled during the reporting period (1/1/00 to 12/31/00), with only one gap in enrollment for a period of no more than 30 days, who had a periodic examination from a dentist. Children who were enrolled in a plan and switched to another product line of that plan should be considered continuously enrolled. Comparative data on this measure was not found.

Chart 4



Standard deviation is (+/- 9%) for 1999 and (+/- 6%) for 2000.

Source: 2000 and 2001 audited Dental Quality reports from plans.

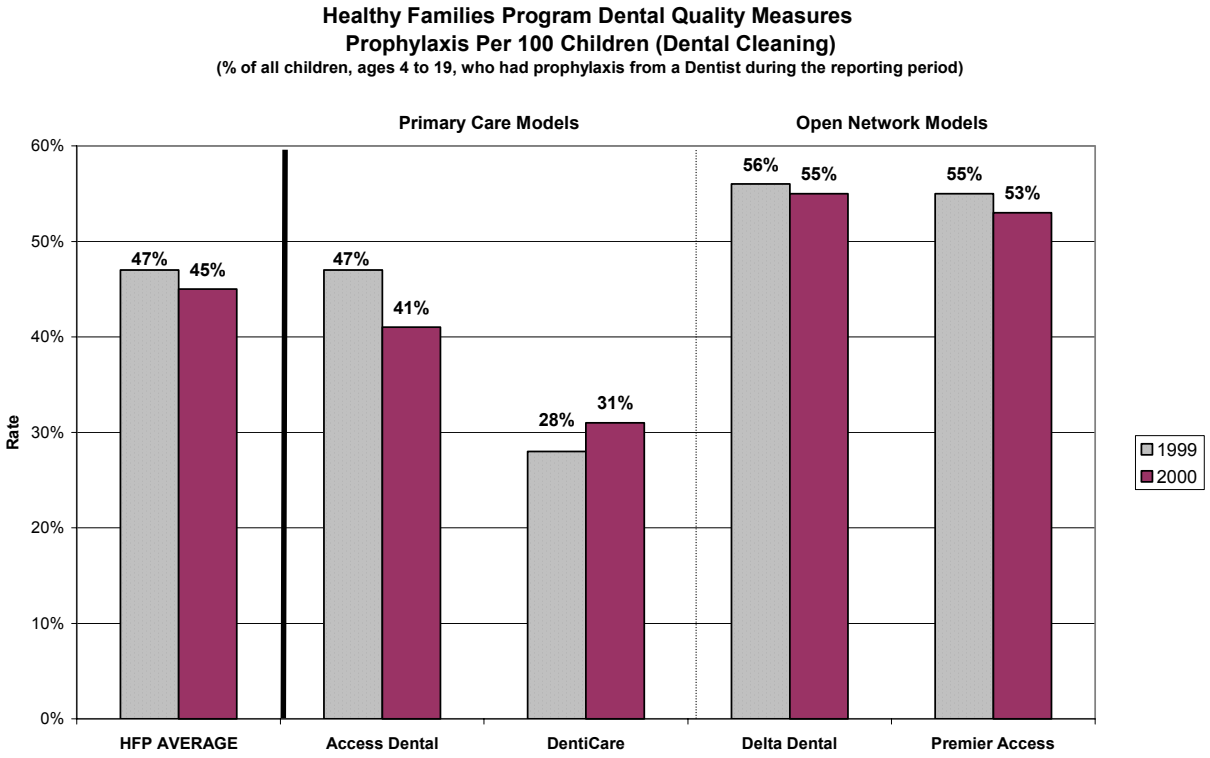
Premier Access is 1 standard deviation above the HFP average in 1999 and 2000

Universal Care Dental had an insufficient number of eligible members to participate in measures.

Prophylaxis per 100 children

This measure is the percentage of all children between the ages of 4 and 19 years of age, who were continuously enrolled during the reporting period (1/1/00 to 12/31/00), with only one gap in enrollment for a period of no more than 30 days, who received prophylaxis from a dentist. Children who were enrolled in a plan and switched to another product line of that plan were considered continuously enrolled. Comparative data on this measure was not found.

Chart 5



Standard deviation is (+/- 13%) in 1999 and (+/- 11%) in 2000. Source: 2000 and 2001 Annual Dental Quality reports from plans.

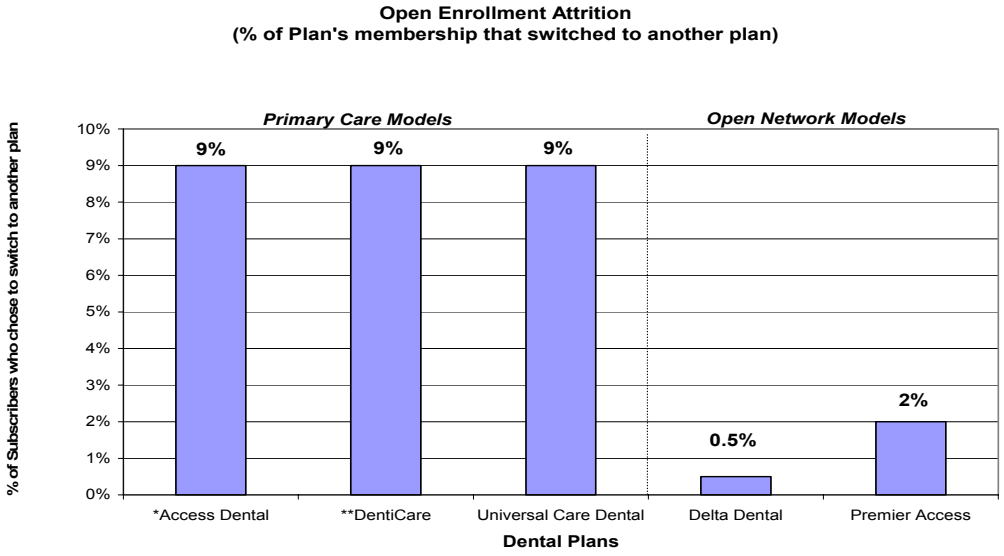
DentiCare is 1 standard deviation below the HFP average in 1999 and 2000.

Universal Care Dental had an insufficient number of eligible members to participate in measures.

Open Enrollment in the Healthy Families Dental Program

In April of each year, families with children enrolled in HFP can change their child's health, dental or vision plans. This process is called "open enrollment". In 2001, only four percent of 415,887 families chose to switch their child's dental plan. Of those members choosing to switch plans at open enrollment, the majority of subscribers switched from Primary Care Model plans to Open Network Model plans.

Chart 6

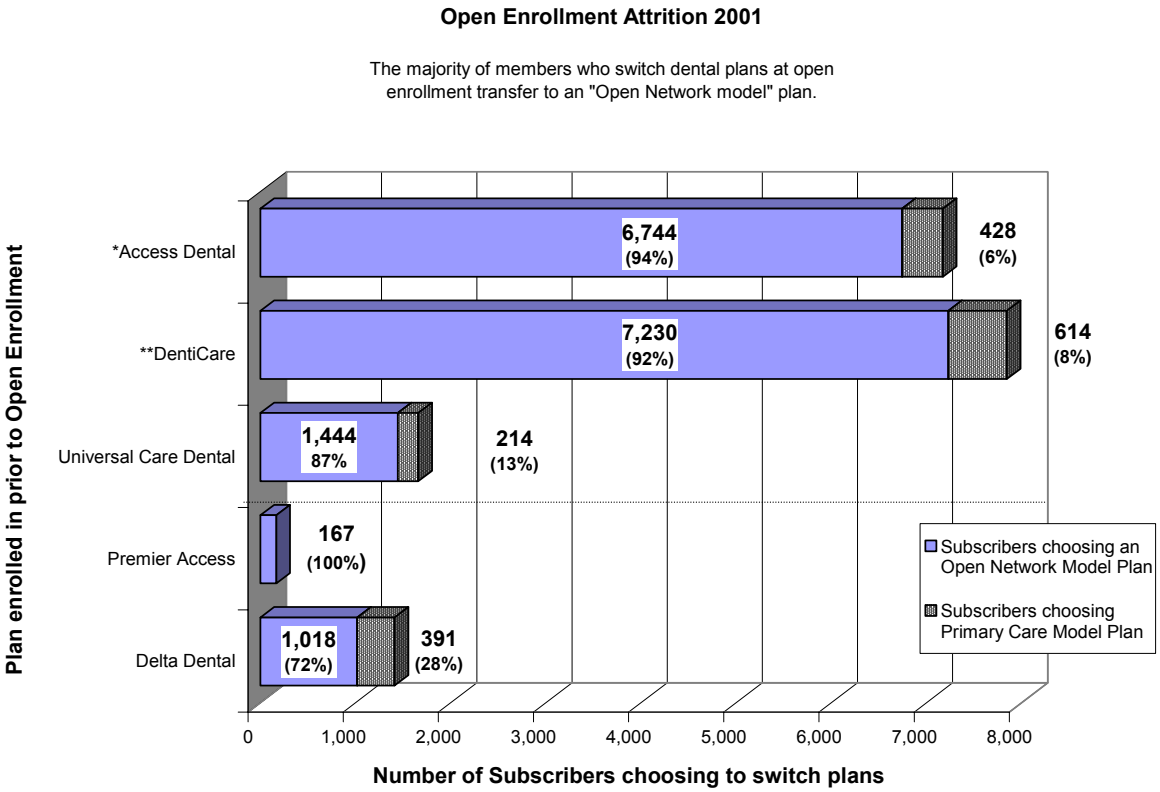


Source: Data extracted for Summary of Total Open Enrollment Changes, HFP Board meeting on October 17, 2001, Agenda Item #3d.

The majority of members who switched dental plans at open enrollment transferred to "Open Network Model" plans. Less than 3% of subscribers in Open Network model plans chose to switch to another dental plan, whereas 9% of subscribers in the Primary Care model chose to switch. The Open Network model may be the preferred model for HFP subscribers because it provides access to greater numbers of dentists and because research from the healthcare arena indicates that there is a perception by consumers that broad provider choices equate to higher quality.

Every family that requests a change of plan(s) is asked to complete a survey as part of the open enrollment transfer process[9]. The largest number of respondents (35% of the cases) indicated they voluntarily changed their dental plan because they had a problem getting a dentist with whom they were happy. It is important to note that survey respondents were allowed to indicate more than one response as the reason for changing plans.

Chart 7



*Access Dental replaced its Primary Care model with its Open Network model, Premier Access, in seven counties. Approximately 1700 children were required to transfer. Some of these "mandatory" transfers enrolled in Premier Access and are included in the number of subscribers shown as choosing to switch from Access Dental.
**DentiCare was closed in El Dorado and Placer counties. Approximately 100 subscribers were required to transfer from DentiCare. These "mandatory" transfers are included in the number of subscribers shown as choosing to switch from DentiCare.

[9] Open Enrollment summary report, Healthy Families Board Meeting Agenda item #3d, October 17, 2001.

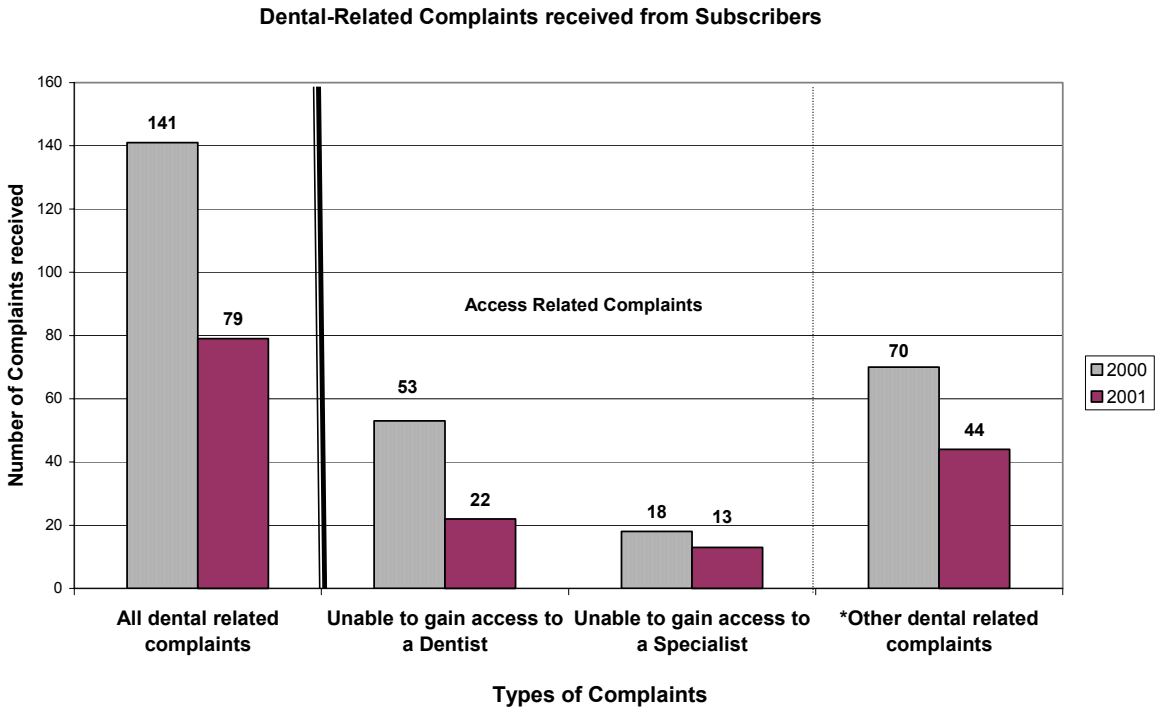
Access-related Complaints from Subscribers

Subscribers with concerns about their dental plans are first referred to the plan's member service department. In addition, each plan's coverage document includes information on the Department of Managed Health Care's or Department of Insurance's consumer complaint lines. MRMIB receives some calls directly from the subscribers.

In 2000, MRMIB received 141 complaints related to HFP dental plans. Seventy-one of those were access related. Of the seventy-one access related complaints, 53 (75%) were attributed to the inability to locate a dentist in the subscriber's dental plan network in the applicant's area of residence. During 2001, a total of 79 complaints were received by MRMIB for dental access-related issues. In 2001, there was a 42% reduction in access-related complaints attributed to applicants having difficulties finding a dental provider. In both years, the number of subscribers who lodged a complaint constituted less than 1% of the total HFP population in that year.

Most access-related complaints occurred when a subscriber had difficulty finding a dentist or specialist to provide services to them in their area of residence. In these instances, MRMIB staff assisted members in locating a provider in their area. When necessary, MRMIB staff worked directly with the dental plans to address subscriber difficulties and obtain a provider to serve them.

Chart 8



Source: Information extracted form HFP Benefits' Complaints and Appeals tracking database, January 11, 2001

*Other dental related complaints include transfer requests, unpaid or denied claims, quality of care, benefits/coverage and referrals/out of network services.

Consumer Satisfaction with Dental Plans Survey Results

In 2002, the first-ever consumer survey of dental plans was conducted by MRMIB to assess families' experiences with their children's dental plans. The survey was conducted using an instrument that was developed by RAND and based on the Consumer Assessment of Health Plan Survey (CAHPS)®. RAND is part of the research consortium that developed the CAHPS® instrument eight years ago. The HFP dental survey is the first time the Dental CAHPS® instrument has been used.

The instrument contains 63 questions pertaining to several aspects of dental care. The aspects of dental care that were covered in the survey include: access to care, customer service, communication of providers, quality and satisfaction of dental plan services and dental care received. The responses have been summarized into four global rating and five composite scores. The global ratings included rating of dental care, dental plan, dental office or clinic, and specialist. The composite scores addressed getting needed care, getting care quickly, how well the dental providers communicate and helpfulness and courteousness of dental office staff and customer service.

Families with children between the ages of 4 and 18, who had been continuously enrolled in the dental plan for at least 12 months as of December 31, 2001, were randomly selected from each participating dental plan. All five participating dental plans were included in the survey. The sample size for each dental plan was 1,050 families. Families asked to participate in the survey received the survey in English and Spanish, Vietnamese, Korean and Chinese if one of these languages was designated as the primary language on the families' HFP application. Over 5,000 families were selected for the survey. Of those families selected for the survey, 55%[10] responded.

The survey was conducted in five languages—English, Spanish, Vietnamese, Korean and Chinese.

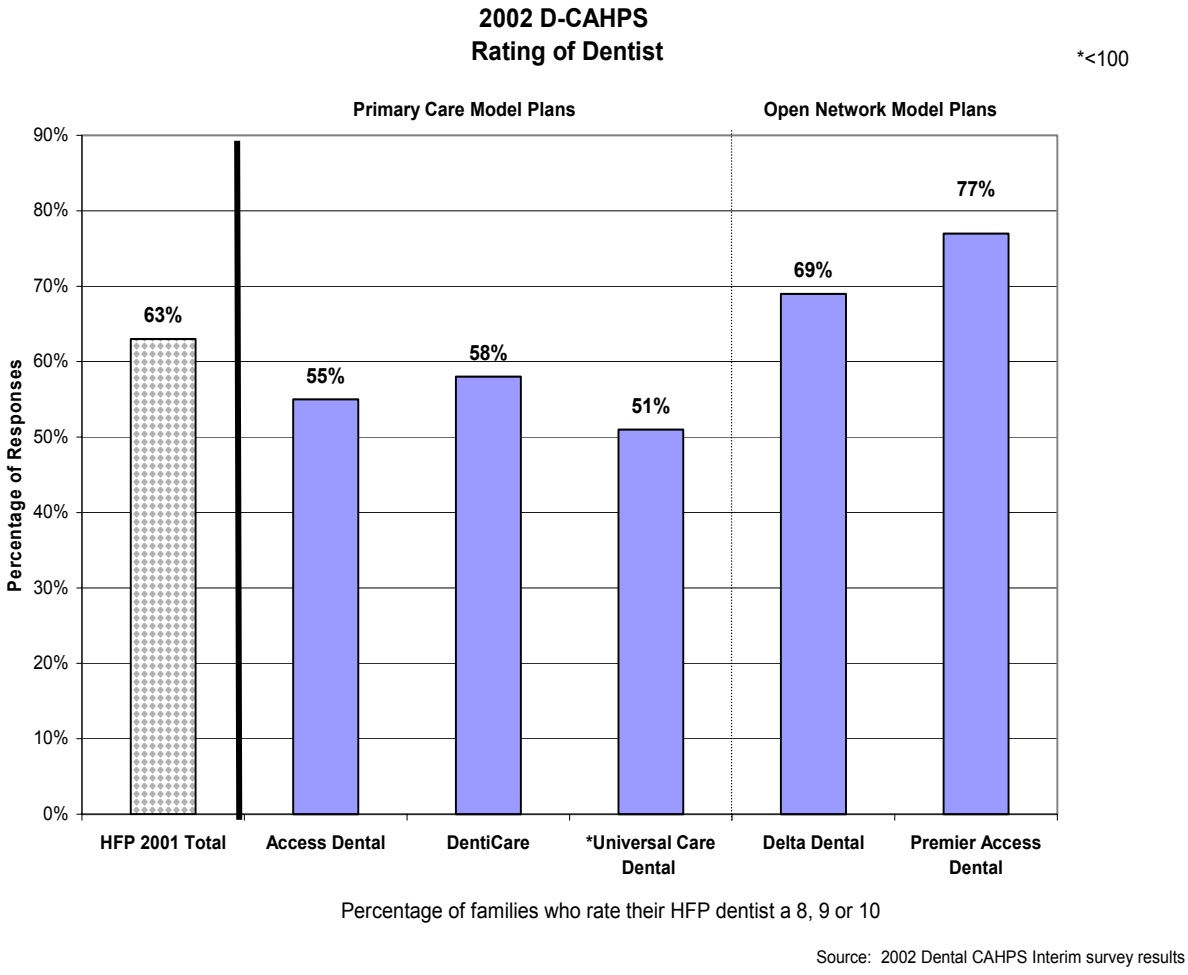
The following charts present the interim results of the survey.

The HFP program-wide average scores indicate that the majority of subscribers give high ratings to their child's HFP dental plan, dentist, and dental services. There is significant variation in scores between plans and between dental plan models. The open network model plans consistently score more than one standard deviation above the program average.

[10] This is the interim survey response percentage. It may change after the final survey reconciliation by the survey vendor in May, 2002.

Rating of Dentist

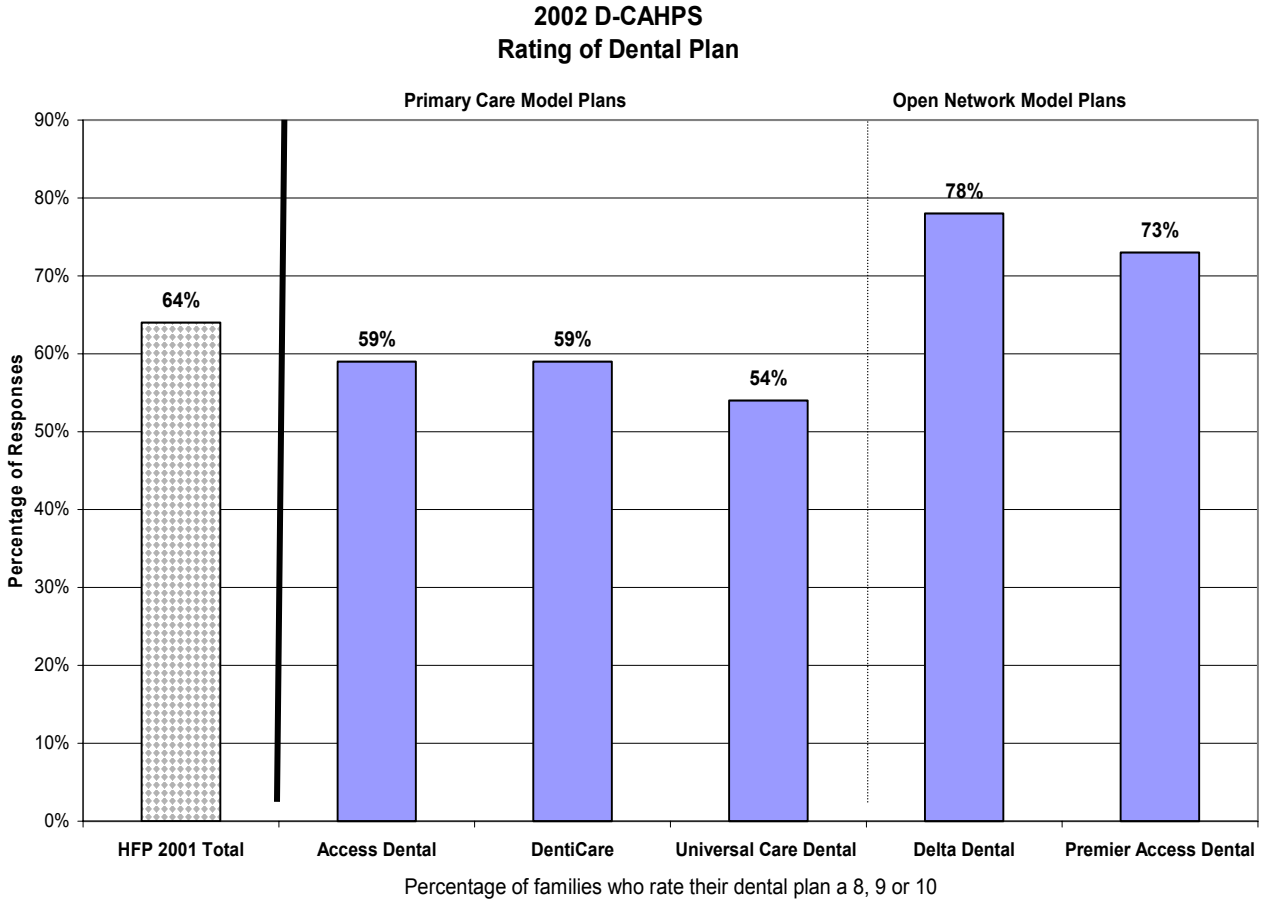
This graph shows answers to a survey question that asked families in each plan to rate their child's dental office or clinic on a scale of 0 = "worst dentist office or clinic possible" to 10 = "best dental office or clinic possible" based on their experiences in the last 12 months.



The scores of all plans are more than one standard deviation above or below the HFP average.

Rating of Dental Plan

This graph shows answers to a survey question that asked families in each plan to rate their child's dental plan on a scale of 0 = "worst dental plan possible" to 10 = "best dental plan possible" based on their experiences in the last 12 months.



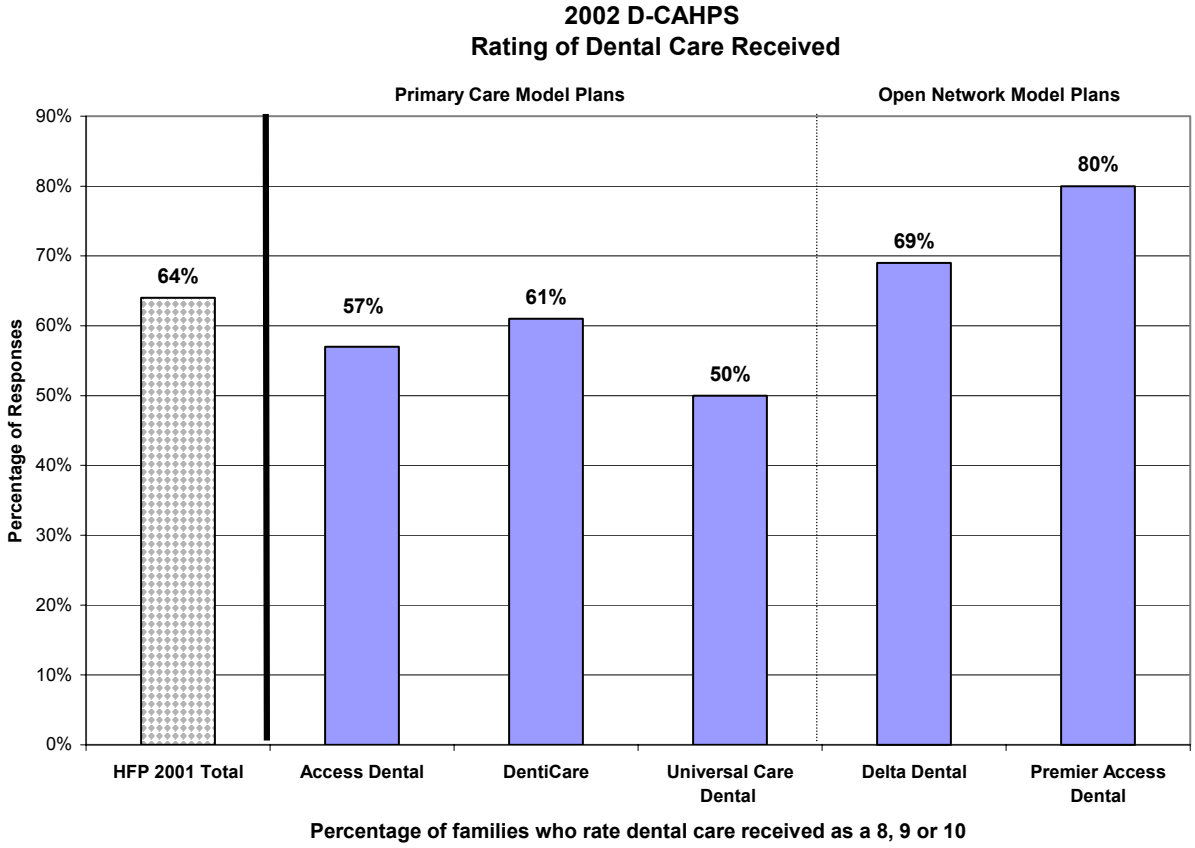
Source: 2002 Dental CAHPS Interim survey results

The scores of all plans are more than one standard deviation above or below the HFP average.

Note: Plan scores were clustered at both ends of the range of scores which resulted in a mean score that was different from all individual plan scores.

Rating of Dental Care

This graph shows answers to a survey question that asked families in each plan to rate the dental care their child received from all dental offices and clinics on a scale of 0 = "worst dental care possible" to 10 = "best dental care possible" based on their experiences in the last 12 months.



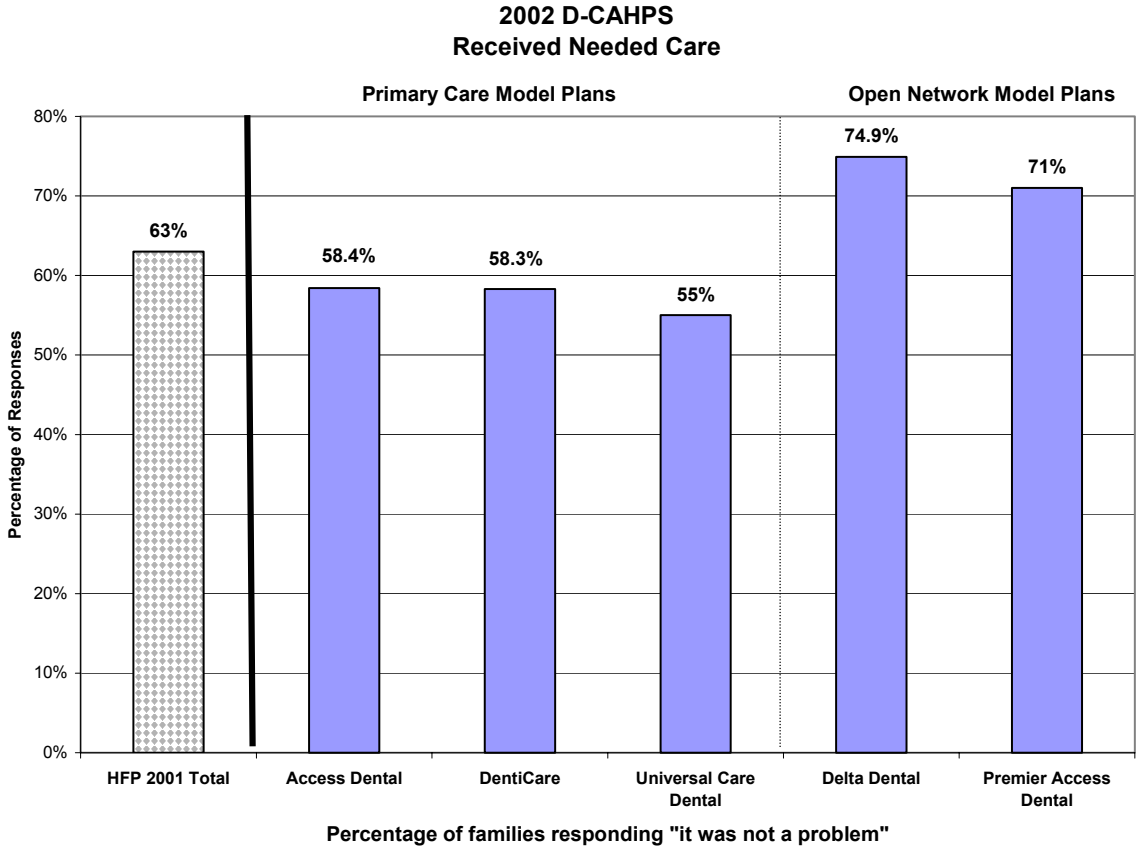
Source: 2002 Dental CAHPS Interim survey results

The scores of all plans are more than one standard deviation above or below the HFP average.

Getting Dental Care Needed

This graph shows answers to 4 survey questions that asked families how much of a problem in the last 12 months, if any, it was to:

- Find a dental office or clinic for your child you are happy with
- Get a referral to a dental specialist that your child needed to see
- Get dental care for your child that you or a dentist believed necessary
- Get care approved by their child's dental plan without delays



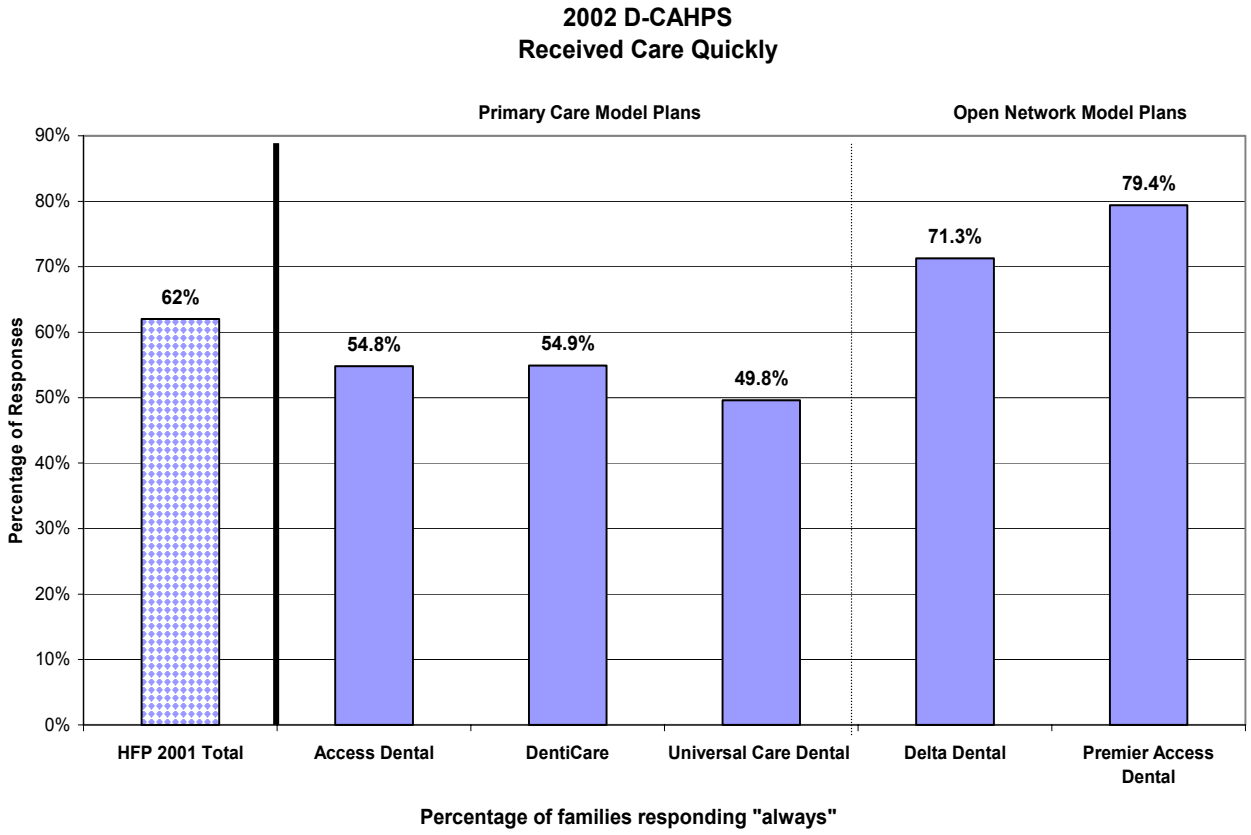
Source: 2002 Dental CAHPS Interim survey results

The scores of all plans are more than one standard deviation above or below the HFP average.

Getting Dental Care Quickly

This graph shows answers to 5 questions that asked families how often in the last 12 months did they:

- Get the help or advice you needed for their child when they called during regular office hours
- Get an appointment to fill or treat a cavity for their child as soon as they wanted
- Get an appointment for their child for regular or routine health care as soon as they wanted
- Get care right away for mouth pain or a dental problem
- Wait less than 15 minutes past the appointment time to see the person your child went to see



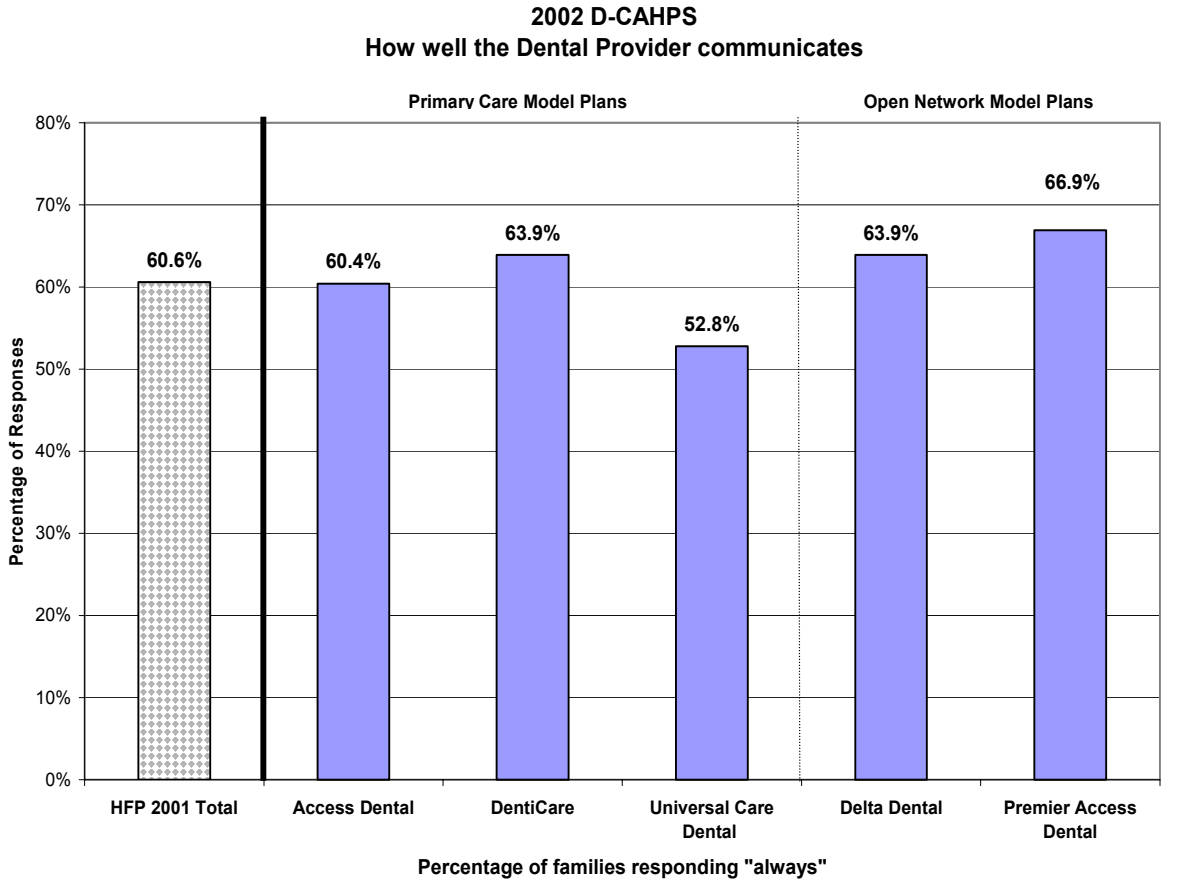
Source: 2002 Dental CAHPS Interim survey results

The scores of all plans are more than one standard deviation above or below the HFP average.

How Well Dental Providers Communicate

This graph shows answers to 5 survey questions that asked families how often in the last 12 months their child's dentist or other dental provider

- Listened carefully to them
- Explained things in a way they could understand
- Did not have a hard time speaking or understanding the dental provider because they spoke a different language
- Showed respect for what you had to say
- Spend enough time with your child



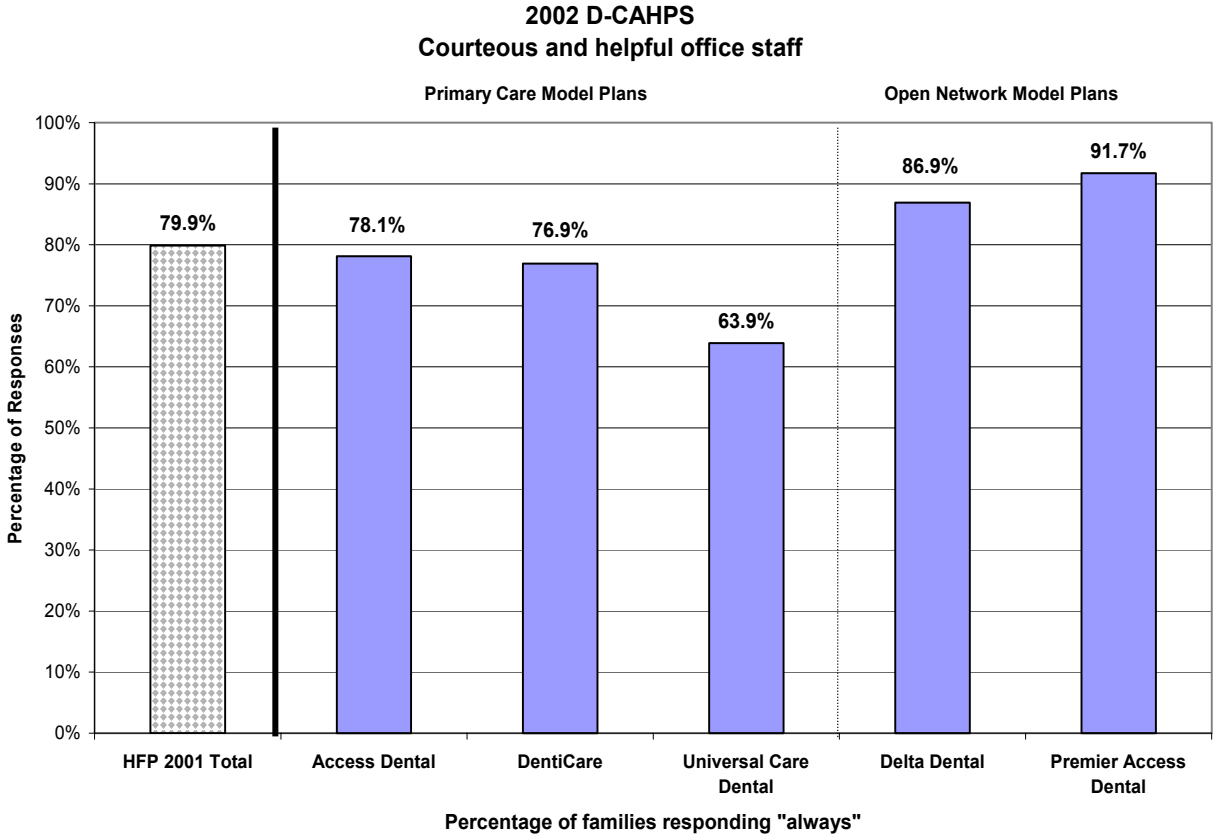
Source: 2002 Dental CAHPS Interim survey results

The scores of DentiCare, Universal Care Dental, Delta Dental and Premier Access Dental are more than one standard deviation above or below the HFP average.

Courteous and Helpful Office Staff

This graph shows answers to 2 survey questions that asked families how often in the last 12 months the office staff at their child's dental office or clinic:

- Treat them and their child with courtesy and respect
- Were as helpful as you thought they should be



Source: 2002 Dental CAHPS Interim survey results

The scores of Universal Care Dental, Delta Dental and Premier Access Dental are more than one standard deviation above or below the HFP average.

Orthodontic Services

One area that has been of particular interest with regard to children's dental care is access to orthodontic services. Orthodontic treatment is available through the HFP in limited circumstances via linkage to the Department of Health Services, California Children's Services (CCS) program. Orthodontic treatment that is solely cosmetic in nature is not a covered benefit in the HFP or CCS programs. The HFP Model Dental Plan Contract requires dental plans to refer children suspected of having a CCS-eligible condition to the local CCS office for assessment, diagnosis, and treatment. When a dental plan or provider refers a child to CCS for assessment, the child must be screened according to CCS guidelines.

Screening clinics serve "state-only" CCS-eligible children and HFP CCS-eligible children. Screenings may occur in a CCS sponsored screening clinic or a private orthodontist's office. Most local county programs hold screening clinics at least annually. Counties with larger populations usually hold screening clinics more frequently. The type of screening method selected by each county program is based on the number of children referred for screening and the number of CCS paneled orthodontists available to do the screening. For example, children in smaller rural counties like Siskiyou, Modoc, and Del Norte go to a private orthodontist for eligibility screening. Two CCS paneled orthodontists are required to conduct individual screenings. A third review may be required if there is a difference between the two screening results.

By contrast, screening of Medi-Cal CCS-eligible children is performed in dental offices on an as needed basis. The screening results for Medi-Cal CCS-eligible children are reviewed centrally and must be approved by Denti-Cal professional staff.

Children who are eligible for CCS orthodontic services must have a "handicapping dental malocclusion" as determined using a standardized rating tool and the following prerequisite conditions:

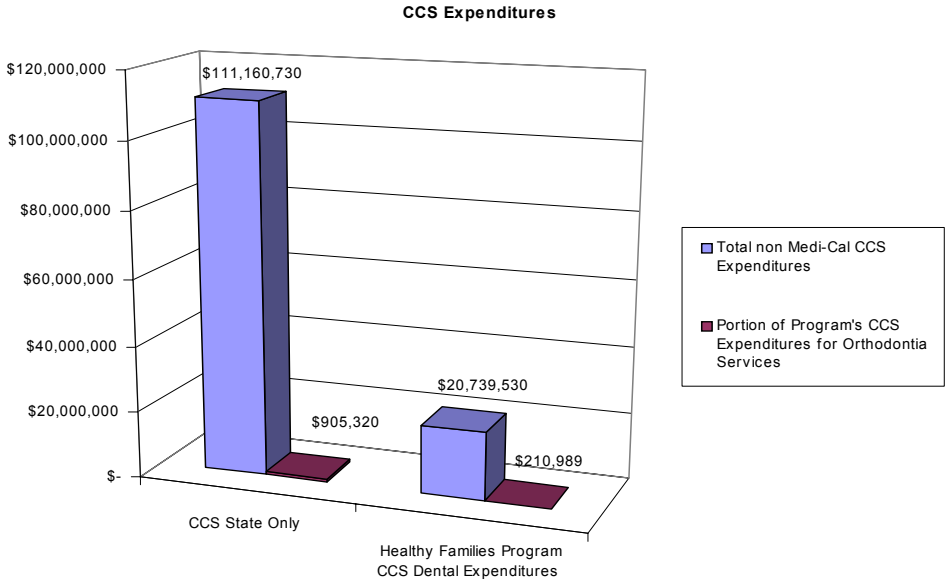
- Willingness of parent and child to comply
- Child has all of his/her permanent teeth

Before implementation of orthodontic treatment, children must have caries (cavities) under control with acceptable oral hygiene evident.

Are Children Enrolled in the HFP Receiving Orthodontic Services through CCS?

HFP dental plans made 962 referrals to CCS for dental treatment in the 2001 calendar year. In 2001, local CCS programs spent $210,989[11] on orthodontic treatment for eligible Healthy Families subscribers. This represents 19% of CCS non Medi-Cal expenditures for Orthodontic services in 2001.

The chart below shows a comparison of state-only CCS costs to HFP CCS expenditures for orthodontic services. The data indicates that spending for orthodontic treatment in the state-only CCS program is consistent with spending in the HFP CCS program.



Source: Department of Health Services, CCS Program, March 2002

[11] Information from statistical report generated by Department of Health Services, CCS expenditures in March, 2002.

Improvements in Access to CCS Orthodontic Treatment

MRMIB staff met with the Department of Health Services, Children's Medical Services Branch (CMS) to discuss orthodontic services in the CCS Program. CMS staff is working with the California Association of Orthodontists (CAO) to eliminate barriers to screenings and to increase participation of CAO members in the CCS program.

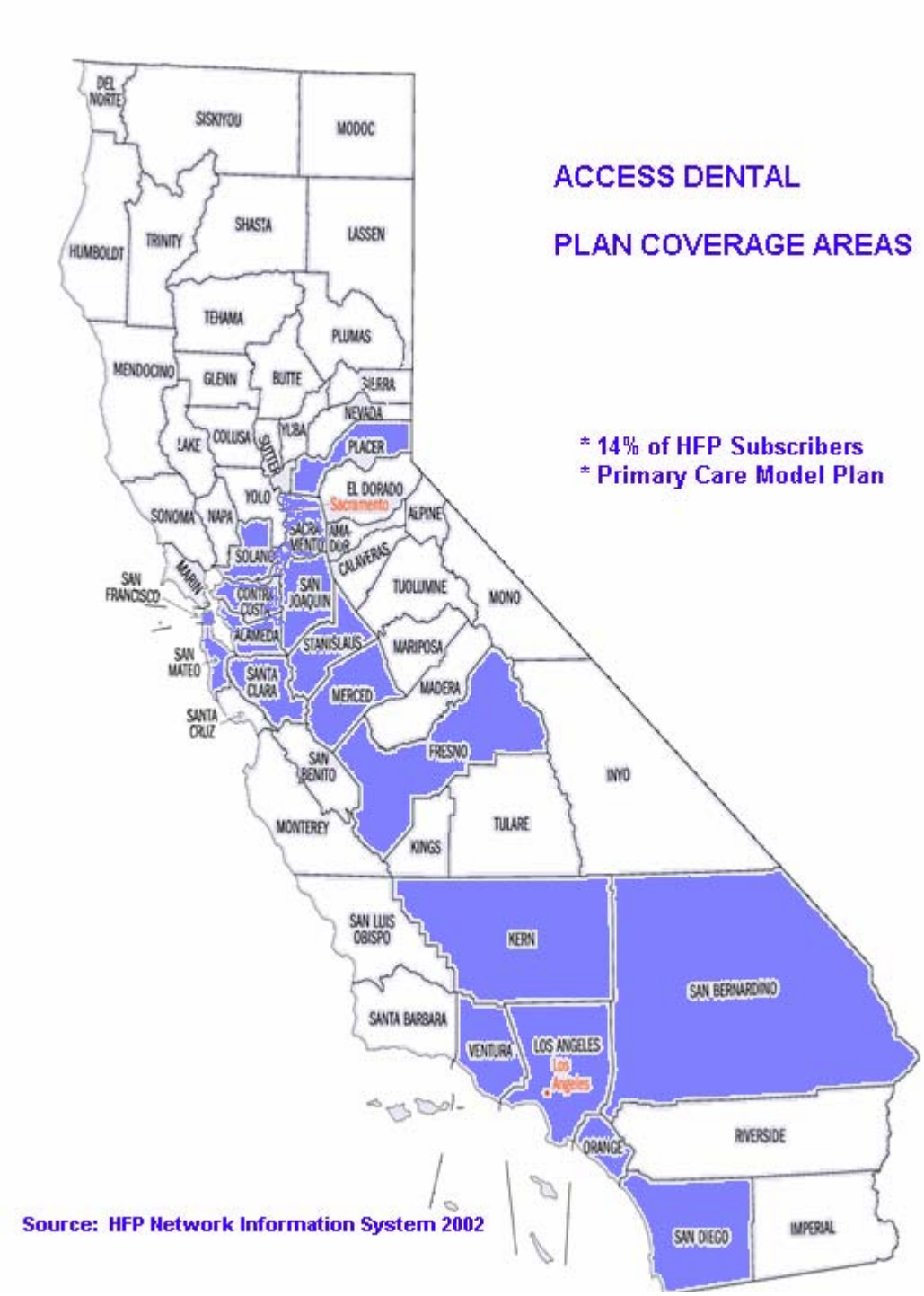
The following activities are underway to streamline the CCS orthodontic program for implementation in fall 2002.

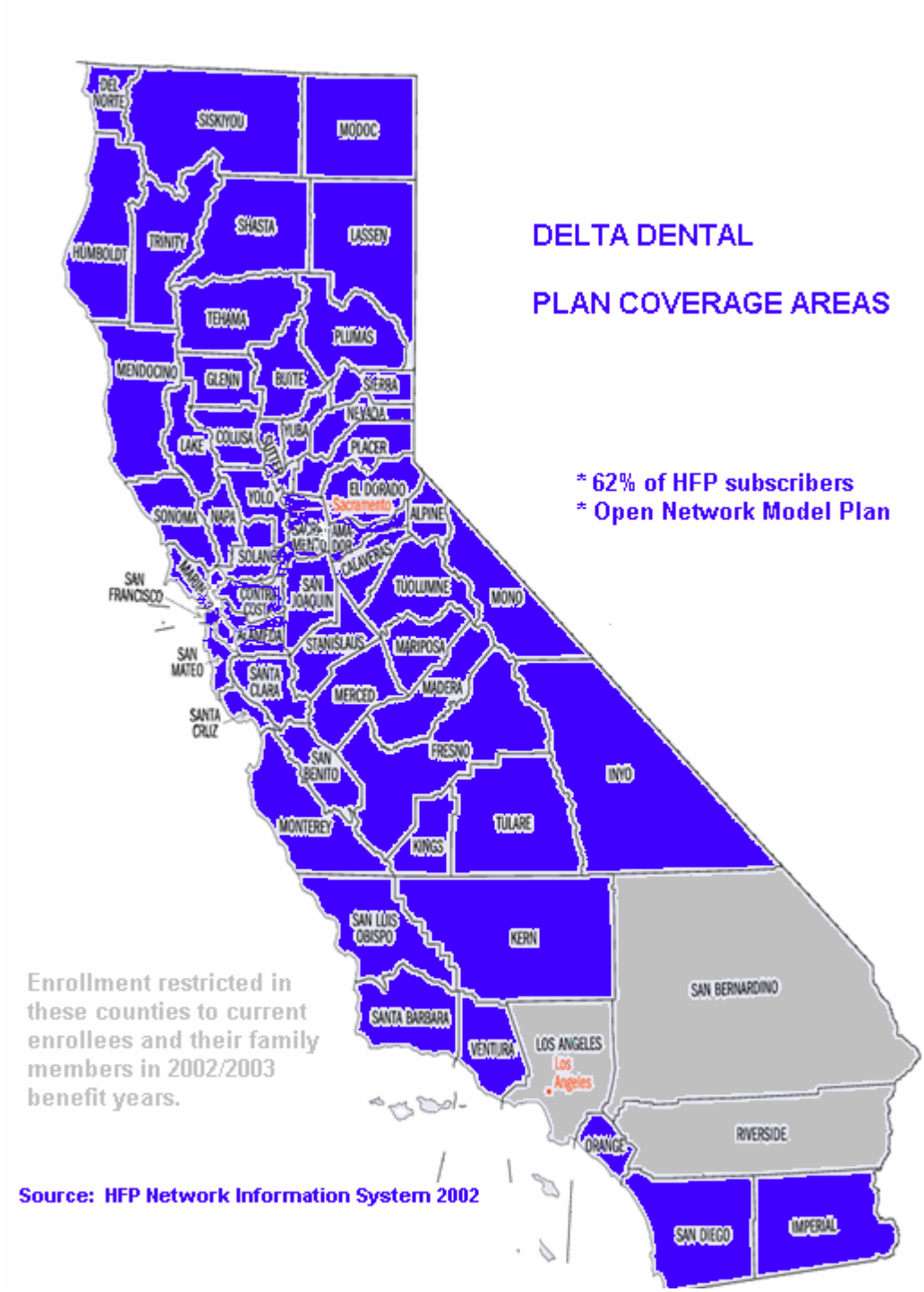
- CCS will use the same fiscal intermediary as Denti-Cal. This will enable providers to bill for orthodontic services using procedures codes and forms familiar to orthodontists.

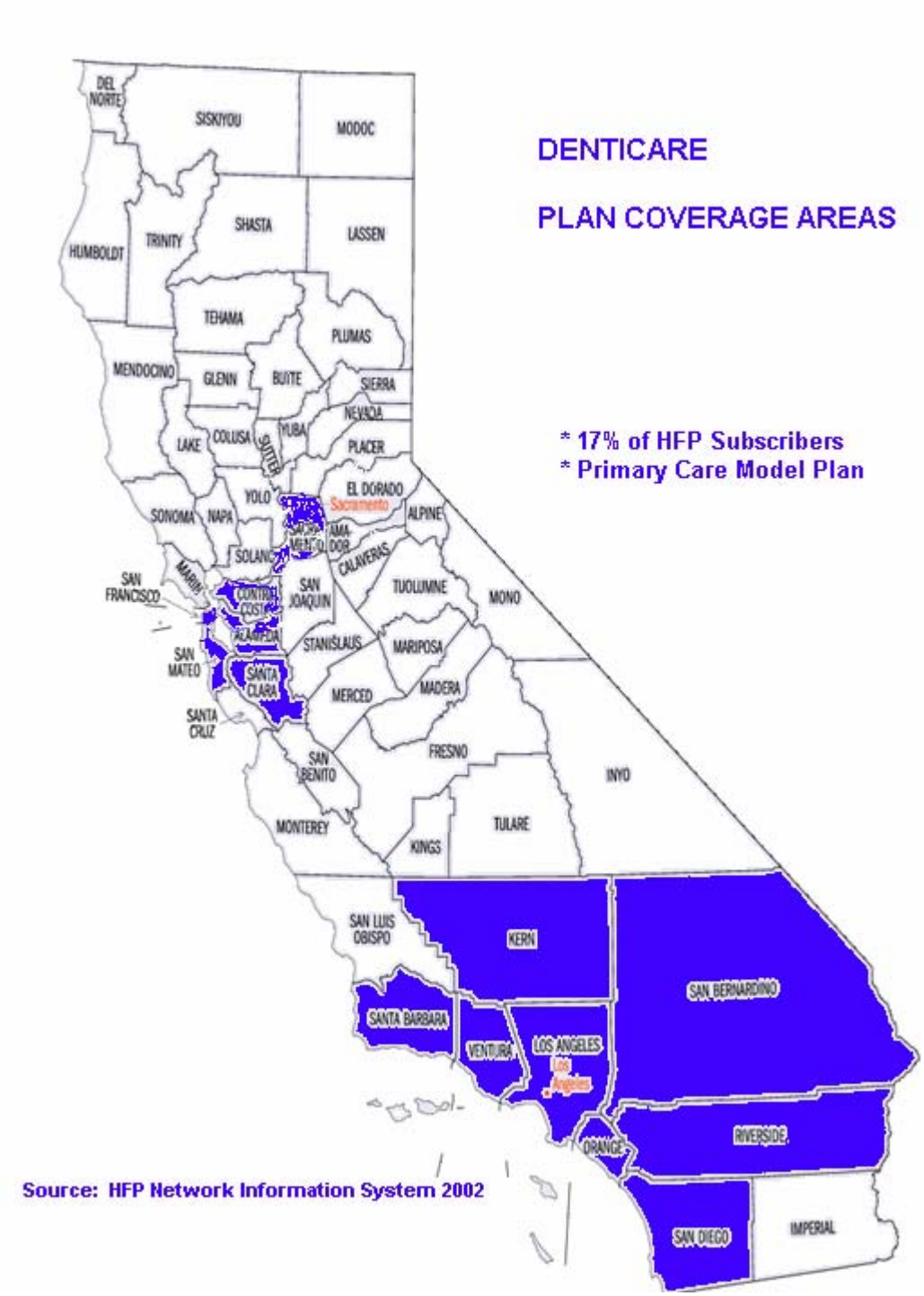
- CCS is revising its policies to conform to Denti-Cal policy. The revised policy will provide clarification and more precise guidance for county CCS programs on screening criteria for handicapping malocclusion, authorization for treatment, and processing of claims.

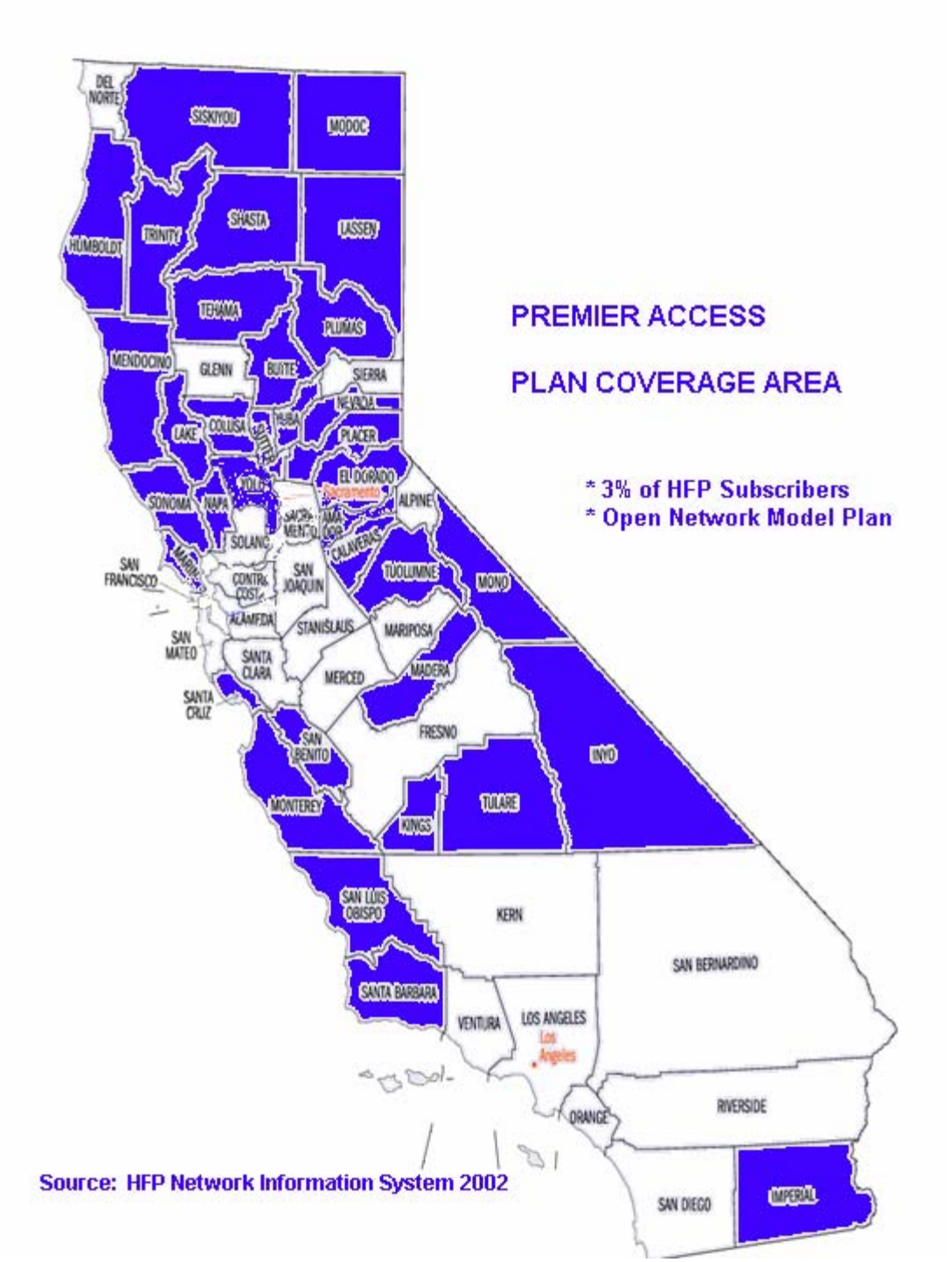
- CCS has asked CAO to assist them in recruiting orthodontists to work as consultants to screen for handicapping malocclusion. This will provide an alternative to the CCS orthodontic screening clinic process.

- CCS is revising its policies to include a 120 day referral requirement. All children referred to CCS will be screened for eligibility within 120 days of referral to their local CCS office. This will increase access to eligibility screening which should enable more children to receive the CCS orthodontic treatment they may need.


ACCESS DENTAL
PLAN COVERAGE AREAS
* 14% of HFP Subscribers
* Primary Care Model Plan
Source: HFP Network Information System 2002
DEL NORTE
SISKIYOU
MODOC
HUMBOLDT
TRINITY
SHASTA
LASSEN
TEHAMA
PLUMAS
MENDOCINO
GLENN
BUTTE
SIERRA
NEVADA
LAKE
COLUSA
SUTTER
YUBA
PLACER
YOLO
EL DORADO
Sacramento
ALPINE
SONOMA
NAPA
SACRA-MENTO
AMA-DOR
CALAVERAS
SOLANO
MARIN
SAN FRANCISCO
CONTRA COSTA
SAN JOAQUIN
TUOLUMNE
MONO
ALAMEDA
STANISLAUS
MARIPOSA
SAN MATEO
SANTA CLARA
MERCED
MADERA
SANTA CRUZ
SAN BENITO
FRESNO
INYO
MONTEREY
KINGS
TULARE
SAN LUIS OBISPO
KERN
SAN BERNARDINO
SANTA BARBARA
VENTURA
LOS ANGELES
Los Angeles
ORANGE
RIVERSIDE
SAN DIEGO
IMPERIAL


DELTA DENTAL
PLAN COVERAGE AREAS
* 62% of HFP subscribers
* Open Network Model Plan
Enrollment restricted in these counties to current enrollees and their family members in 2002/2003 benefit years.
Source: HFP Network Information System 2002
DEL NORTE
SISKIYOU
MODOC
HUMBOLDT
TRINITY
SHASTA
LASSEN
TEHAMA
PLUMAS
MENDOCINO
GLENN
BUTTE
SIERRA
NEVADA
LAKE
COLUSA
YUBA
PLACER
SUTTER
YOLO
EL DORADO
Sacramento
SONOMA
NAPA
ALPINE
AMA DOR
CALAVERAS
SOLANO
SAN FRANCISCO
MARIN
CONTRA COSTA
SAN JOAQUIN
TUOLUMNE
MONO
ALAMEDA
STANISLAUS
MARIPOSA
SAN MATEO
SANTA CLARA
MERCED
MADERA
SANTA CRUZ
FRESNO
SAN BENITO
INYO
MONTEREY
TULARE
KINGS
SAN LUIS OBISPO
KERN
SAN BERNARDINO
SANTA BARBARA
VENTURA
LOS ANGELES
Los Angeles
RIVERSIDE
ORANGE
SAN DIEGO
IMPERIAL


DENTICARE
PLAN COVERAGE AREAS
* 17% of HFP Subscribers
* Primary Care Model Plan
Source: HFP Network Information System 2002
DEL NORTE
SISKIYOU
MODOC
HUMBOLDT
TRINITY
SHASTA
LASSEN
TEHAMA
PLUMAS
MENDOCINO
GLENN
BUTTE
SIERRA
NEVADA
LAKE
COLUSA
SUTTER
YUBA
PLACER
YOLO
EL DORADO
Sacramento
ALPINE
SONOMA
NAPA
SAN JOAQUIN
AMADOR
CALAVERAS
SOLANO
MARIN
SAN FRANCISCO
CONTRA COSTA
ALAMEDA
TUOLUMNE
MONO
SAN MATEO
SANTA CLARA
STANISLAUS
MARIPOSA
MERCED
MADERA
SANTA CRUZ
SAN BENITO
FRESNO
INYO
MONTEREY
KINGS
TULARE
SAN LUIS OBISPO
KERN
SAN BERNARDINO
SANTA BARBARA
VENTURA
LOS ANGELES
Los Angeles
ORANGE
RIVERSIDE
SAN DIEGO
IMPERIAL


PREMIER ACCESS
PLAN COVERAGE AREA
* 3% of HFP Subscribers
* Open Network Model Plan
Source: HFP Network Information System 2002
DEL NORTE
SISKIYOU
MODOC
HUMBOLDT
TRINITY
SHASTA
LASSEN
TEHAMA
PLUMAS
MENDOCINO
GLENN
BUTTE
SIERRA
NEVADA
LAKE
COLUSA
YUBA
PLACER
EL DORADO
SONOMA
NAPA
YOLO
Sacramento
ALPINE
SACRA-MENTO
AMA-DOR
CALAVERAS
SOLANO
MARIN
SAN FRANCISCO
CONTRA COSTA
SAN JOAQUIN
TUOLUMNE
MONO
ALAMEDA
STANISLAUS
MARIPOSA
SAN MATEO
SANTA CLARA
MERCED
MADERA
SANTA CRUZ
FRESNO
SAN BENITO
INYO
MONTEREY
KINGS
TULARE
SAN LUIS OBISPO
KERN
SAN BERNARDINO
SANTA BARBARA
VENTURA
LOS ANGELES
Los Angeles
ORANGE
RIVERSIDE
SAN DIEGO
IMPERIAL


UNIVERSAL CARE DENTAL
PLAN COVERAGE AREAS
* 4% of HFP Subscribers
* Primary Care Model Plan
Source: HFP Network Information System 2002
DEL NORTE
SISKIYOU
MODOC
HUMBOLDT
TRINITY
SHASTA
LASSEN
TEHAMA
PLUMAS
MENDOCINO
GLENN
BUTTE
SIERRA
NEVADA
LAKE
COLUSA
YUBA
SUTTER
PLACER
YOLO
EL DORADO
Sacramento
SONOMA
NAPA
ALPINE
SACRA-MENTO
AMA-DOR
SOLANO
CALAVERAS
SAN FRANCISCO
MARIN
CONTRA COSTA
SAN JOAQUIN
TUOLUMNE
MONO
ALAMEDA
STANISLAUS
MARIPOSA
SAN MATEO
SANTA CLARA
MERCED
MADERA
SANTA CRUZ
FRESNO
INYO
SAN BENITO
MONTEREY
KINGS
TULARE
SAN LUIS OBISPO
KERN
SAN BERNARDINO
SANTA BARBARA
VENTURA
LOS ANGELES
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ORANGE
RIVERSIDE
SAN DIEGO
IMPERIAL